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INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

# CERTIFICATE OF DEATH

08443

Reg. Dist. No. 100

08439

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Charles</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Charles</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>JULIAN C. BLACKLOCK</u>		<b>4. DATE OF DEATH</b> (Month) <u>8</u> (Day) <u>24</u> (Year) <u>1957</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>W</u>	<b>8. DATE OF BIRTH</b> <u>March 25, 1871</u>
<b>9. AGE last birthday</b> <u>86</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Buyer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Tobacco</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Frederick Sydney Blacklock</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Julia Swann</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>No.</u>	
<b>17. INFORMANT &amp; ADDRESS</b> <u>J. Sydney Blacklock, Bel Air, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
<b>18. MEDICAL CERTIFICATION</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 8-5-57, to 8-24-57, that I last saw the deceased alive on 8-14-57, and that death occurred at 7 A.M. from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <u>E. J. Delaney</u>		<b>DATE SIGNED</b> <u>8-24-57</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>24. REC'D BY REGISTRAR</b> <u>Julia H. Pacey</u>	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Huntt Funeral Home, Waldorf, Md.</u>		<b>26. ADDRESS</b> <u>La Plata, Md.</u>	

# MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

## CERTIFICATE OF DEATH

<p>NAME OF DECEASED <i>John A. Smith</i></p> <p>AGE <i>45</i></p> <p>SEX <i>Male</i></p> <p>RACE <i>White</i></p> <p>DATE OF BIRTH <i>March 1, 1910</i></p> <p>PLACE OF BIRTH <i>St. Louis, Mo.</i></p> <p>RESIDENCE <i>1234 Main St., Baltimore, Md.</i></p> <p>OCCUPATION <i>Teacher</i></p> <p>CAUSE OF DEATH <i>Heart Disease</i></p> <p>PERMANENT ADDRESS <i>1234 Main St., Baltimore, Md.</i></p>	<p>DATE OF DEATH <i>August 15, 1957</i></p> <p>PLACE OF DEATH <i>Home</i></p> <p>TIME OF DEATH <i>10:30 AM</i></p> <p>DECEASED'S SIGNATURE <i>John A. Smith</i></p> <p>DECEASED'S ADDRESS <i>1234 Main St., Baltimore, Md.</i></p> <p>DECEASED'S OCCUPATION <i>Teacher</i></p> <p>DECEASED'S DATE OF BIRTH <i>March 1, 1910</i></p> <p>DECEASED'S SEX <i>Male</i></p> <p>DECEASED'S RACE <i>White</i></p> <p>DECEASED'S AGE <i>45</i></p> <p>DECEASED'S PLACE OF BIRTH <i>St. Louis, Mo.</i></p> <p>DECEASED'S RESIDENCE <i>1234 Main St., Baltimore, Md.</i></p> <p>DECEASED'S OCCUPATION <i>Teacher</i></p> <p>DECEASED'S CAUSE OF DEATH <i>Heart Disease</i></p> <p>DECEASED'S PERMANENT ADDRESS <i>1234 Main St., Baltimore, Md.</i></p>
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**BUREAU V. S.**

AUG 30 1957

**RECEIVED**

*8/15/57*

## CERTIFICATE OF DEATH

Reg. Dist. No.

08444

100

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> <b>LA PLATA</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRYANTOWN (rural)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>PHYSICIANS Memorial</b>				e. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) <b>George Forbes</b> First Middle Last				4. DATE OF DEATH <b>Aug. 18</b> Month Day Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OF FACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 20 1905</b>	9. AGE (In years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Albert Bowling</b>			14. MOTHER'S MAIDEN NAME <b>Eleanor Forbes</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-28-974</b>			17. INFORMANT <b>Ella M Bowling</b> Address <b>Bryantown Md</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Heart Disease</b> DUE TO (c) <b>640.0</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <b>AUG. 18</b> , 19 <b>57</b> , to <b>AUG. 18</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>AUG. 18</b> , 19 <b>57</b> , and that death occurred at <b>11:35 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. PARRAN PARBOE</b> M.D.			ADDRESS (Street, city or town, state) <b>La Plata Md</b>		DATE SIGNED <b>8-19-57</b>		
PHYSICIAN'S NAME (Type) <b>J. PARRAN PARBOE M.D.</b>							
22a. BURIAL, CREMATION, or other disposal (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
<b>Burial</b>	<b>Aug 21 1957</b>	<b>St Mary's</b>		<b>Bryantown Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hunt Funeral Home</b>			ADDRESS <b>Waldorf Md</b>		24a. REC'D BY REGISTRAR DATE <b>8/21/57</b>	24b. REGISTRAR'S SIGNATURE <b>John H. Bailey</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased: *Robert Bowling*

2. Sex: *Male*

3. Age: *34*

4. Date of Birth: *Aug 26 1923*

5. Place of Birth: *St. Louis, Mo.*

6. Date of Death: *Aug 26 1957*

7. Time of Death: *10:30 PM*

8. Cause of Death: *Myocardial Infarction*

9. Place of Death: *Home*

10. Signature of Physician: *[Signature]*

11. Signature of Registrar: *[Signature]*

12. Date of Registration: *Aug 27 1957*

13. File Number: *100-100000-100000*

BUREAU V. 1

AUG 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08445

08441

CERTIFICATE OF DEATH

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laplace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Newport</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Phy Mem Hosp</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anthony Chapman</u>				4. DATE OF DEATH Month Day Year <u>Aug 26 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 10, 1904</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser Laundry</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>William J Chapman</u>				14. MOTHER'S MAIDEN NAME <u>Greene Campbell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Army</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>George V Chapman</u>				Address <u>Washington Dc</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Neoplasm</u> <u>193X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>uncertain</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>23 August, 1957</u> , to <u>26 August, 1957</u> , that I last saw the deceased alive on <u>24 August, 1957</u> , and that death occurred at <u>5:07 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>V B Settor</u>				ADDRESS (Street, city or town, state) <u>La Plata, Md.</u>			
DATE SIGNED <u>27 Aug. 1957</u>							
PHYSICIAN'S NAME (Type) <u>V. B. DETTOR M.D.</u>				LA PLATA, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 29, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Civilington Natl</u>		22d. LOCATION (City, town, or county) (State) <u>Civilington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest H. Laplace</u>				ADDRESS <u></u>		24a. REC'D BY REGISTRAR DATE <u>8/28/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Julius H. Boney</u>							



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF CORONER		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	
21. SIGNATURE OF REGISTRAR		22. SIGNATURE OF CLERK		23. SIGNATURE OF JURY		24. SIGNATURE OF JUDGE		25. SIGNATURE OF SHERIFF	
26. SIGNATURE OF DISTRICT ATTORNEY		27. SIGNATURE OF COUNTY CLERK		28. SIGNATURE OF COUNTY COMMISSIONER		29. SIGNATURE OF COUNTY SHERIFF		30. SIGNATURE OF COUNTY JUDGE	
31. SIGNATURE OF COUNTY CLERK		32. SIGNATURE OF COUNTY COMMISSIONER		33. SIGNATURE OF COUNTY SHERIFF		34. SIGNATURE OF COUNTY JUDGE		35. SIGNATURE OF COUNTY CLERK	
36. SIGNATURE OF COUNTY COMMISSIONER		37. SIGNATURE OF COUNTY SHERIFF		38. SIGNATURE OF COUNTY JUDGE		39. SIGNATURE OF COUNTY CLERK		40. SIGNATURE OF COUNTY COMMISSIONER	
41. SIGNATURE OF COUNTY SHERIFF		42. SIGNATURE OF COUNTY JUDGE		43. SIGNATURE OF COUNTY CLERK		44. SIGNATURE OF COUNTY COMMISSIONER		45. SIGNATURE OF COUNTY SHERIFF	
46. SIGNATURE OF COUNTY JUDGE		47. SIGNATURE OF COUNTY CLERK		48. SIGNATURE OF COUNTY COMMISSIONER		49. SIGNATURE OF COUNTY SHERIFF		50. SIGNATURE OF COUNTY JUDGE	
51. SIGNATURE OF COUNTY CLERK		52. SIGNATURE OF COUNTY COMMISSIONER		53. SIGNATURE OF COUNTY SHERIFF		54. SIGNATURE OF COUNTY JUDGE		55. SIGNATURE OF COUNTY CLERK	
56. SIGNATURE OF COUNTY COMMISSIONER		57. SIGNATURE OF COUNTY SHERIFF		58. SIGNATURE OF COUNTY JUDGE		59. SIGNATURE OF COUNTY CLERK		60. SIGNATURE OF COUNTY COMMISSIONER	
61. SIGNATURE OF COUNTY SHERIFF		62. SIGNATURE OF COUNTY JUDGE		63. SIGNATURE OF COUNTY CLERK		64. SIGNATURE OF COUNTY COMMISSIONER		65. SIGNATURE OF COUNTY SHERIFF	
66. SIGNATURE OF COUNTY JUDGE		67. SIGNATURE OF COUNTY CLERK		68. SIGNATURE OF COUNTY COMMISSIONER		69. SIGNATURE OF COUNTY SHERIFF		70. SIGNATURE OF COUNTY JUDGE	
71. SIGNATURE OF COUNTY CLERK		72. SIGNATURE OF COUNTY COMMISSIONER		73. SIGNATURE OF COUNTY SHERIFF		74. SIGNATURE OF COUNTY JUDGE		75. SIGNATURE OF COUNTY CLERK	
76. SIGNATURE OF COUNTY COMMISSIONER		77. SIGNATURE OF COUNTY SHERIFF		78. SIGNATURE OF COUNTY JUDGE		79. SIGNATURE OF COUNTY CLERK		80. SIGNATURE OF COUNTY COMMISSIONER	
81. SIGNATURE OF COUNTY SHERIFF		82. SIGNATURE OF COUNTY JUDGE		83. SIGNATURE OF COUNTY CLERK		84. SIGNATURE OF COUNTY COMMISSIONER		85. SIGNATURE OF COUNTY SHERIFF	
86. SIGNATURE OF COUNTY JUDGE		87. SIGNATURE OF COUNTY CLERK		88. SIGNATURE OF COUNTY COMMISSIONER		89. SIGNATURE OF COUNTY SHERIFF		90. SIGNATURE OF COUNTY JUDGE	
91. SIGNATURE OF COUNTY CLERK		92. SIGNATURE OF COUNTY COMMISSIONER		93. SIGNATURE OF COUNTY SHERIFF		94. SIGNATURE OF COUNTY JUDGE		95. SIGNATURE OF COUNTY CLERK	
96. SIGNATURE OF COUNTY COMMISSIONER		97. SIGNATURE OF COUNTY SHERIFF		98. SIGNATURE OF COUNTY JUDGE		99. SIGNATURE OF COUNTY CLERK		100. SIGNATURE OF COUNTY COMMISSIONER	

RECEIVED  
AUG 30 1957  
BUREAU V. S.

08442

08446/00

## CERTIFICATE OF DEATH

Reg. Dist. No.

782

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>				c. LENGTH OF STAY IN TB <b>30 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PHYSICIANS MEMORIAL Hospital</b>				d. STREET ADDRESS <b>RURAL BRANDYWINE</b> XI			
3. NAME OF DECEASED (Type or print) <b>JOSEPH SYLVESTER DE LOZIER</b>				4. DATE OF DEATH <b>AUGUST 17 1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 2-1884</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JOHN WESLEY Buchanan DeLozier</b>				14. MOTHER'S MAIDEN NAME <b>HARRIET THOMPSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>George A. DeLozier Brandywine Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA, STOMACH WITH HEPATIC METASTASES</b> DUE TO <b>151X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>151X</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL 1956</b> , to <b>AUGUST 17, 1957</b> , that I last saw the deceased alive on <b>AUGUST 17, 1957</b> , and that death occurred at <b>6:00 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John H. Griffin</b> M.D.				ADDRESS (Street, city or town, state) <b>Box #65, Hughesville, Md.</b> DATE SIGNED <b>8/17/57</b>			
PHYSICIAN'S NAME (Type) <b>John H. Griffin</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-21-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels</b>		22d. LOCATION (City, town, or county) (State) <b>Ridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. B. Robinson - Leonardtown, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>8/19/57</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Julia R. Posey</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

AUG 20 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08447

Reg. Dist. No. 100

08443

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laplate</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Papus Creek</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Phy mem Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John Frederick Drinks</i>				4. DATE OF DEATH <i>Aug 16 1957</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec 16 1883</i>	
9. AGE (In years last birthday) <i>73</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Resturant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore</i>		11. BIRTHPLACE (State or foreign country) <i>W.D.A.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>W.D.A.</i>				13. FATHER'S NAME <i>Charles J</i>			
14. MOTHER'S MAIDEN NAME <i>Pora C Bauler</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <i>George W Robertson</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Gen Art. Sclerosis</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>8-15-57</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <i>11</i> p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>8-15-57</i> to <i>8-16-57</i> , that I last saw the deceased alive on <i>8-16-57</i> , and that death occurred at <i>9:15</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>E. J. Edelen</i> M.D.				ADDRESS (Street, city or town, state) <i>8-16-57</i>			
PHYSICIAN'S NAME (Type) <i>E. J. EDELEN MD</i>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug 19 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Christ Church</i>		22d. LOCATION (City, town, or county) (State) <i>wayside md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rehert Mc Laplate md.</i>				24a. REC'D BY REGISTRAR <i>8/19/57</i>		24b. REGISTRAR'S SIGNATURE <i>Julia H. Posen</i>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

44

JUN 22 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08448

08444

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>New Jersey</u> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL ALTON, RURAL</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elizabeth</u> 67X-9	
		f. STREET ADDRESS <u>460 Newport Road</u>	
3. NAME OF DECEASED (Type or print) First <u>BRADLEY</u> Middle <u>ELMORE</u> Last <u>JR.</u>		4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-31</u>
9. AGE (In years last birthday) <u>25</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FISHERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ATLANTIC NAVIG-VIRGINIA</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BRADLEY ELMORE, SR.</u>		14. MOTHER'S MAIDEN NAME <u>CORAENE NOEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>Funeral Home Records</u>	
17. INFORMANT <u>Funeral Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Surgical shock</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Multiple Compound Fractures-left extremity</u> DUE TO (c) <u>10 minutes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>STRUCK BY AUTO</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>11:30</u> a.m. <u>8-23</u> 19 <u>57</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>STREET</u>		20f. (City or town) (County) (State) <u>BEL ALTON, CHARLES, MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>V.B. DETTOR</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V.B. DETTOR, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/24/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Edwardsville</u>		22d. LOCATION (City, town, or county) (State) <u>Edwardsville, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wheeler Inc. Laplata, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8/26/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Julia H. Porey</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please note the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

AUG 28 1957

RECEIVED

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 08445 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08449

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Issue</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Ignatius</u> Last <u>Hill</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1924</u>
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing</u>	11. BIRTHPLACE (State or foreign country) <u>Charles Co Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John C. Hill</u>	
14. MOTHER'S MAIDEN NAME <u>Bertha Donley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>215-26-3470</u>		17. INFORMANT <u>Hella Chisby</u> Address <u>Welcome Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Art Arteriosclerosis</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>8-22-57</u> <u>??</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. EDELEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8-24-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/26-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>	22d. LOCATION (City, town, or county) (State) <u>Issue Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wheeler McLaughlin</u>		ADDRESS <u>Md</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Julia H. Posey</u>	

MEDICAL CERTIFICATION

2



RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

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VS. A15ME(5)  
5M 9/55

08446

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08450

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Alexander</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Summit</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexander</u> 83X-3.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>R.F.D. 3 Box 460 D</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Corbett</u> Middle <u>Little</u> Last <u>Corbett</u>		4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-22-18</u>
9. AGE (in years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin Little</u>		14. MOTHER'S MAIDEN NAME <u>India Roberts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>204-12-0290</u>	
17. INFORMANT <u>Joan Bridger</u> Address <u>Alexander Va</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>850X</u> DUE TO <u>Drowning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>8-17-57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Severed from boat which drifted away, he couldn't swim to</u>	
20c. TIME OF INJURY Month, Day, Year <u>8-17-57</u> Hour <u>8</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Boat</u>		20f. City or town <u>Summit</u> (County) <u>Charles</u> (State) <u>VA</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. EDELEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		22b. DATE THEREOF <u>8/20/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) <u>Alexander</u> (State) <u>VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Greghart Inc. Laplatard</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u>8/26/57</u>		24b. REGISTRAR'S SIGNATURE <u>Julia A. Posey</u>	

AUG 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

08447

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08451

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Chas</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Phys. Men Hosp</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ELLA</u> First <u>MAKLE</u> Middle <u>MAKLE</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-1-06</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>12</u> Hours <u>12</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Chapman</u>		14. MOTHER'S MAIDEN NAME <u>Annette</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mary Hagans</u>		Address <u>WALDORE, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN DEATH AND DEATH <u>8-11-57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. EDEHEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDEHEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-15-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST PETERS CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WALDORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>WALDORE, MD.</u>	
24a. REC'D BY REGISTRAR <u>AUG 14 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Julius P. P...</u>	

STATE OF NEW YORK  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED J. J. J.		AGE 45		SEX M		RACE W		DATE OF DEATH 8-14-57		PLACE OF DEATH H	
RESIDENCE 1234 5th Ave		CITY New York		COUNTY New York		STATE New York		ZIP 10001		MARRIAGE M	
OCCUPATION Salesman		EDUCATION High School		RELIGION Catholic		MILITARY SERVICE None		PREVIOUS ILLNESS None		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		TOXICOLOGY None		ALCOHOL None		DRUGS None		SMOKING Cigarettes		OTHER None	
SIGNATURE OF EXAMINER J. J. J.		TITLE Medical Examiner		COMMISSION EXPIRATION 8-14-58		HONORARY None		FEE \$10.00		REMARKS None	

BUREAU V. S.

AUG 14 1957

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The foregoing copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 (10M)

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08448

## CERTIFICATE OF DEATH

08452/106

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Indian Head Md</u>		<u>two months</u>		TOWN <u>Finksburg-Md</u>		<u>06X02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>163 B Indian Head Hwy</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Wilbert Isham Randle</u>				<u>8-1-57</u> 19 <u>57</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<u>Male</u>	<u>White-US</u>	<u>Married</u>	<u>1-29-1875</u> <u>1-29-1875</u>	<u>82</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Minister</u>		<u>Methodist</u>		<u>Warsaw Illinois</u>		<u>US</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>James Pickett Randle</u>				<u>Nancy Stephenson</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>		<b>18. MEDICAL CERTIFICATION</b>	
<u>No</u>		<u>None</u>		<u>Janna L. Randle -Son</u>		<u>Indian Head Maryland</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Acute Congestive Heart Failure</u>				<u>7-days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>Coronary Heart Disease</u>				<u>Indefinite</u>			
(C) <u>Arteriosclerosis</u>				<u>Indefinite</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>450.0</u>							
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>5-25-57</u>, 19<u>57</u>, that I last saw the deceased alive on <u>8-1-57</u>, 19<u>57</u>, and that death occurred at <u>9:30 PM</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>James E. Randle</u> M.D.				<b>DATE SIGNED</b> <u>8-1-57</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>ADDRESS</b> (Street, city, town, state)			
<u>Burial</u>				<u>17-Potomac Ave Indian Head Md</u>			
<b>24. REC'D BY REGISTRAR</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)			
<u>8-4-57</u>		<u>Jessops Methodist</u>		<u>Sparks, Maryland</u>			
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>					
<u>Edney Price</u>		<u>622 York Rd</u>		<u>Towson 4, Md.</u>			
<b>DATE</b> <u>AUG 5 1957</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08449

CERTIFICATE OF DEATH

084535  
105

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WALDORF</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 WALDORF</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE ADRAIN RICHARDS</b>				4. DATE OF DEATH Month Day Year <b>AUG 10 1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 18 1899</b>		9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>George W. Richards</b>				14. MOTHER'S MAIDEN NAME <b>DELAIDE DOWNS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>CLARA MAY RICHARDS WALDORF MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Apoplexy</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes Mellitus</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1955</b> to <b>Aug 9 1957</b> , that I last saw the deceased alive on <b>8-9-57</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b>				ADDRESS (Street, city or town, state) <b>Waldorf MD</b> DATE SIGNED <b>8-10-57</b>			
PHYSICIAN'S NAME (Type) <b>GEORGE S. WEBER M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-12-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST PAUL'S CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>WALDORF MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home</b> ADDRESS <b>WALDORF, MD.</b>				24a. REC'D BY REGISTRAR <b>[Signature]</b> DATE <b>AUG 13 1957</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

CERTIFICATE OF DEATH

8213

1. NAME OF DECEASED <i>Charles H. [illegible]</i>		2. SEX <i>Male</i>	
3. AGE <i>40</i>		4. DATE OF BIRTH <i>1917</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>None</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>1940</i>	
9. NAME OF SPOUSE <i>[illegible]</i>		10. DATE OF DEATH <i>Aug 12 1957</i>	
11. CAUSE OF DEATH <i>Heart Disease</i>		12. PLACE OF DEATH <i>Home</i>	
13. SIGNATURE OF PHYSICIAN <i>[illegible]</i>		14. SIGNATURE OF REGISTRAR <i>[illegible]</i>	
15. SIGNATURE OF WITNESS <i>[illegible]</i>		16. SIGNATURE OF WITNESS <i>[illegible]</i>	
17. SIGNATURE OF WITNESS <i>[illegible]</i>		18. SIGNATURE OF WITNESS <i>[illegible]</i>	
19. SIGNATURE OF WITNESS <i>[illegible]</i>		20. SIGNATURE OF WITNESS <i>[illegible]</i>	
21. SIGNATURE OF WITNESS <i>[illegible]</i>		22. SIGNATURE OF WITNESS <i>[illegible]</i>	
23. SIGNATURE OF WITNESS <i>[illegible]</i>		24. SIGNATURE OF WITNESS <i>[illegible]</i>	
25. SIGNATURE OF WITNESS <i>[illegible]</i>		26. SIGNATURE OF WITNESS <i>[illegible]</i>	
27. SIGNATURE OF WITNESS <i>[illegible]</i>		28. SIGNATURE OF WITNESS <i>[illegible]</i>	
29. SIGNATURE OF WITNESS <i>[illegible]</i>		30. SIGNATURE OF WITNESS <i>[illegible]</i>	
31. SIGNATURE OF WITNESS <i>[illegible]</i>		32. SIGNATURE OF WITNESS <i>[illegible]</i>	
33. SIGNATURE OF WITNESS <i>[illegible]</i>		34. SIGNATURE OF WITNESS <i>[illegible]</i>	
35. SIGNATURE OF WITNESS <i>[illegible]</i>		36. SIGNATURE OF WITNESS <i>[illegible]</i>	
37. SIGNATURE OF WITNESS <i>[illegible]</i>		38. SIGNATURE OF WITNESS <i>[illegible]</i>	
39. SIGNATURE OF WITNESS <i>[illegible]</i>		40. SIGNATURE OF WITNESS <i>[illegible]</i>	
41. SIGNATURE OF WITNESS <i>[illegible]</i>		42. SIGNATURE OF WITNESS <i>[illegible]</i>	
43. SIGNATURE OF WITNESS <i>[illegible]</i>		44. SIGNATURE OF WITNESS <i>[illegible]</i>	
45. SIGNATURE OF WITNESS <i>[illegible]</i>		46. SIGNATURE OF WITNESS <i>[illegible]</i>	
47. SIGNATURE OF WITNESS <i>[illegible]</i>		48. SIGNATURE OF WITNESS <i>[illegible]</i>	
49. SIGNATURE OF WITNESS <i>[illegible]</i>		50. SIGNATURE OF WITNESS <i>[illegible]</i>	
51. SIGNATURE OF WITNESS <i>[illegible]</i>		52. SIGNATURE OF WITNESS <i>[illegible]</i>	
53. SIGNATURE OF WITNESS <i>[illegible]</i>		54. SIGNATURE OF WITNESS <i>[illegible]</i>	
55. SIGNATURE OF WITNESS <i>[illegible]</i>		56. SIGNATURE OF WITNESS <i>[illegible]</i>	
57. SIGNATURE OF WITNESS <i>[illegible]</i>		58. SIGNATURE OF WITNESS <i>[illegible]</i>	
59. SIGNATURE OF WITNESS <i>[illegible]</i>		60. SIGNATURE OF WITNESS <i>[illegible]</i>	
61. SIGNATURE OF WITNESS <i>[illegible]</i>		62. SIGNATURE OF WITNESS <i>[illegible]</i>	
63. SIGNATURE OF WITNESS <i>[illegible]</i>		64. SIGNATURE OF WITNESS <i>[illegible]</i>	
65. SIGNATURE OF WITNESS <i>[illegible]</i>		66. SIGNATURE OF WITNESS <i>[illegible]</i>	
67. SIGNATURE OF WITNESS <i>[illegible]</i>		68. SIGNATURE OF WITNESS <i>[illegible]</i>	
69. SIGNATURE OF WITNESS <i>[illegible]</i>		70. SIGNATURE OF WITNESS <i>[illegible]</i>	
71. SIGNATURE OF WITNESS <i>[illegible]</i>		72. SIGNATURE OF WITNESS <i>[illegible]</i>	
73. SIGNATURE OF WITNESS <i>[illegible]</i>		74. SIGNATURE OF WITNESS <i>[illegible]</i>	
75. SIGNATURE OF WITNESS <i>[illegible]</i>		76. SIGNATURE OF WITNESS <i>[illegible]</i>	
77. SIGNATURE OF WITNESS <i>[illegible]</i>		78. SIGNATURE OF WITNESS <i>[illegible]</i>	
79. SIGNATURE OF WITNESS <i>[illegible]</i>		80. SIGNATURE OF WITNESS <i>[illegible]</i>	
81. SIGNATURE OF WITNESS <i>[illegible]</i>		82. SIGNATURE OF WITNESS <i>[illegible]</i>	
83. SIGNATURE OF WITNESS <i>[illegible]</i>		84. SIGNATURE OF WITNESS <i>[illegible]</i>	
85. SIGNATURE OF WITNESS <i>[illegible]</i>		86. SIGNATURE OF WITNESS <i>[illegible]</i>	
87. SIGNATURE OF WITNESS <i>[illegible]</i>		88. SIGNATURE OF WITNESS <i>[illegible]</i>	
89. SIGNATURE OF WITNESS <i>[illegible]</i>		90. SIGNATURE OF WITNESS <i>[illegible]</i>	
91. SIGNATURE OF WITNESS <i>[illegible]</i>		92. SIGNATURE OF WITNESS <i>[illegible]</i>	
93. SIGNATURE OF WITNESS <i>[illegible]</i>		94. SIGNATURE OF WITNESS <i>[illegible]</i>	
95. SIGNATURE OF WITNESS <i>[illegible]</i>		96. SIGNATURE OF WITNESS <i>[illegible]</i>	
97. SIGNATURE OF WITNESS <i>[illegible]</i>		98. SIGNATURE OF WITNESS <i>[illegible]</i>	
99. SIGNATURE OF WITNESS <i>[illegible]</i>		100. SIGNATURE OF WITNESS <i>[illegible]</i>	

BUREAU V. S.

AUG 12 1957

RECEIVED

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08450

08450

CERTIFICATE OF DEATH

08454

Reg. Dist. No. 788

1. PLACE OF DEATH o. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Hughesville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Elizabeth</b> Last <b>Roberts</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>18</b> Year <b>1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 29, 1874</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Stanley Murray</b>		14. MOTHER'S MAIDEN NAME <b>Emma Tucker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>_____</b>	
17. INFORMANT <b>Heber Roberts, Hughesville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE, LEFT</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ESSENTIAL HYPERTENSION</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August, 1947</b> to <b>August, 1957</b> , that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>John N. Griffin</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>Aug. 24, 1957</b>	<b>Old Fields</b>	<b>Hughesville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hunt Funeral Home, Waldorf, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>8/21/57</b>	24b. REGISTRAR'S SIGNATURE <b>Julius H. Pusey</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55



CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Faint text]</p>		<p>AGE [Faint text]</p>	
<p>SEX [Faint text]</p>		<p>RACE [Faint text]</p>	
<p>DATE OF BIRTH [Faint text]</p>		<p>DATE OF DEATH [Faint text]</p>	
<p>PLACE OF BIRTH [Faint text]</p>		<p>PLACE OF DEATH [Faint text]</p>	
<p>CAUSE OF DEATH [Faint text]</p>		<p>MANNER OF DEATH [Faint text]</p>	
<p>DATE OF EXAMINATION [Faint text]</p>		<p>DATE OF REPORT [Faint text]</p>	
<p>SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>DATE OF SIGNATURE [Faint text]</p>		<p>DATE OF SIGNATURE [Faint text]</p>	

BUREAU V. 1

AUG 26 1957

RECEIVED

TO BE FILED IN THE DEPARTMENT OF HEALTH-BALTIMORE, 18  
TO BE FILED IN THE DEPARTMENT OF HEALTH-BALTIMORE, 18  
TO BE FILED IN THE DEPARTMENT OF HEALTH-BALTIMORE, 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)  
5M 9/55

08451

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08455

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b <b>37 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Radford 83x-3</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>				d. STREET ADDRESS <b>6 Staff Village</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jane</b> Middle <b>Crilly</b> Last <b>Thatcher</b>				4. DATE OF DEATH Month <b>August</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 9, 1879</b>	
9. AGE (In years last birthday) <b>77 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Crilly</b>				14. MOTHER'S MAIDEN NAME <b>Margaret R. Plunkett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>P. Phillip Thatcher, 9 Gamble Ave, Elsmore, Del.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>816X</b> <b>INTERIO-SCLEROTIC HEART DISEASE (CARDIAC DECOMPENSATION)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <b>4 WKS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FRACTURES, RIGHT TIBIA AND FIBULA; LEFT TIBIA</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>X</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>COLLISION OF VEHICLES (2) ON U.S. ROUTE #301</b>					
20c. TIME OF INJURY Month, Day, Year <b>7:35 a.m. 6/25 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HIGHWAY</b>		20f. (City or town) (County) (State) <b>FAULKNER, CHARLES MARYLAND</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John H. Griffin</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John H. Griffin, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <b>8/2/57</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Aug 7, 57 New Cathedral</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Wilmington Del</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard H. Leplata, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>DATE 8/7/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Julia M. Posey</b>			

BUREAU V. S.

AUG 9 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

08456

08452

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Diana</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 27, 1957</u>		9. AGE (In years last birthday) yrs. <u>12</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Joseph Andrew Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Mary Clementine Campbell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Joseph A. Thomas, Newport, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Collapse.</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity -</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. O. Woody</u> M.D.				DATE SIGNED <u>28 Aug 57</u>			
PHYSICIAN'S NAME (Type) <u>A. O. Woody, M.D. La Plata, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Newport, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Joseph A. Thomas, Father, Newport, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>8/29/57</u>		24b. REGISTRAR'S SIGNATURE <u>Julia H. Posen</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

08453

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 219 8-30-57 et

CERTIFICATE OF DEATH

08457

Reg. Dist. No.

105

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>				c. LENGTH OF STAY IN 1b <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Waldorf</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mollie</u> Middle <u>Wood</u> Last <u>Wood</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 17 1893</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Months <u>1</u> Days <u>14</u> Hours <u>1</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Louis Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Delaney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Ada Green</u>		Address <u>Washington D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Endo Vascular Brain Dis</u> DUE TO (c) <u>Alcoholism</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 9.</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>				20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>Aug 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 12</u> , 19 <u>57</u> , and that death occurred at <u>3:05 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Waldorf, Md.</u> DATE SIGNED <u>8-15-57</u>							
ACTUAL SIGNATURE <u>Richard H. D. Odom</u> M.D.				DATE SIGNED <u>8-15-57</u>			
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Aug 17 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Piscataway Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt</u>				ADDRESS <u>Waldorf, Md.</u>		24a. RECEIVED BY REGISTRAR <u>Aug 15 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>M. L. Murray</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
 CERTIFICATE OF DEATH

NAME OF DECEASED <i>Charles H. Herring</i>		SEX Male	
DATE OF BIRTH <i>1902</i>		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Clerk		CAUSE OF DEATH Coronary Thrombosis	
PLACE OF DEATH Baltimore, Md.		DATE OF DEATH August 15, 1957	
SIGNATURE OF DECEASED <i>Charles H. Herring</i>		SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
SIGNATURE OF WITNESS <i>[Signature]</i>		SIGNATURE OF DECEASED <i>[Signature]</i>	

RECEIVED  
 AUG 19 1957  
 BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08458

08454

## CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<b>Mechanicsville, Md. 18x12</b>		<b>Mechanicsville, Md. 18x12</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Daniel F.</b> Middle <b>ZOOK</b> Last <b>ZOOK</b>		4. DATE OF DEATH Month <b>Aug</b> Day <b>23</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 30/1883</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Penn</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Simeon Zook</b>		14. MOTHER'S MAIDEN NAME <b>Mary Fisher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>XXXXXX</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>wife &amp; brother</b>		Address <b>mechanicsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Cardiac Failure</b> DUE TO <b>434.2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO <b>3 YRS</b> (c) <b>associated &amp; Bronchial Asthma</b> DUE TO <b>20+ YRS.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 13</b> , 19 <b>57</b> , to <b>Aug 23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Aug 23</b> , 19 <b>57</b> , and that death occurred at <b>1:55 PM EST</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harmon Jarboe</b> M.D.		ADDRESS (Street, city or town, state) <b>La Plata, Md.</b>	
DATE SIGNED <b>8-23-57</b>			
PHYSICIAN'S NAME (Type) <b>J. PARBAN JARBOE M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-27-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Amish Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Mechanicsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. B. Robinson - Leonardtown, Md.</b>		ADDRESS <b>La Plata, Md.</b>	
24a. REC'D BY REGISTRAR <b>8/26/57</b>		24b. REGISTRAR'S SIGNATURE <b>John P. Papp</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

PLACE OF DEATH		MANNER OF DEATH	
HOSPITAL		NATURAL	
COUNTY		CAUSE OF DEATH	
CITY		DISEASE	
STREET		SYMPTOMS	
AGE		SEX	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		HOURS	
MINUTES		SECONDS	
TEMPERATURE		PULSE	
RESPIRATION		BLOOD PRESSURE	
WEIGHT		HEIGHT	
COMPLEXION		HAIR	
EYES		EARS	
MOUTH		NOSE	
THROAT		LUNGS	
HEART		LIVER	
STOMACH		SPLEEN	
PANCREAS		GALLBLADDER	
BLADDER		RECTUM	
VAGINA		TESTES	
UTERUS		OVARIES	
MILK GLANDS		THYROID GLAND	
ADRENAL GLANDS		PITUITARY GLAND	
HYPOTHYROID GLAND		THYMUS GLAND	
PANCREAS		GALLBLADDER	
BLADDER		RECTUM	
VAGINA		TESTES	
UTERUS		OVARIES	
MILK GLANDS		THYROID GLAND	
ADRENAL GLANDS		PITUITARY GLAND	
HYPOTHYROID GLAND		THYMUS GLAND	

BUREAU V. S.

AUG 27 1957

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